does not ocur, so that fistulæ develop and later stenosis; (3) the condition of the kidney and ureter prior to operation interferes with success, an ascending infection often causing fistulæ. In the 9 cases the operation was necessitated by a ureteral fistula, consecutive to a severe labor or to a vaginal hysterectomy. In order to preserve the functional value of the kidney, the operation should be done as soon as possible after a positive diagnosis has been made, since infection of the kidney occurs easily. The good results obtained, and proved by a number of cases during a prolonged period, indicate that the anastomosis by a button deserves every confidence. Late stenosis has been observed in some cases in which the anastomosis was made with sutures, but never in those made with a button.

The Double Filigree Operation for the Radical Cure of Inguinal Hernia.—McGAVIN (*Brit. Med. Jour.*, August 14, 1909) says that it is the general complaint of surgeons that in inguinal herniæ in patients of poor physique, in elderly subjects, in those whose occupations involve a constantly recurring increase of intra-abdominal pressure, and in any patient in whom such a hernia has recurred or has exceeded the more moderate dimensions, the prospect of accomplishing a really radical cure is extremely remote and in some cases quite impossible. In all cases in which hernia occurs or recurs, the chief factors are: (*a*) the presence or formation of a peritoneal sac; (*b*) the recession or pushing aside of the muscular walls of the inguinal canal; (*c*) the stretching of the fibrous structures covering the canal. The method of making the filigree is described. As perfect asepsis is necessary here, or more so than in the implanting of abdominal filigrees, they should be placed in ether for five minutes, to remove all grease from them, and should be left in the sterilizer in the centre of the boiling area until the moment of implantation, when they are lifted directly from the sterilizer into the wound. The operation is at first conducted exactly as in an ordinary Bassini, except that the aponeurosis should be split to a point rather farther out, and the peritoneum must be more freely separated from the under surface of the conjoined tendon, as must the latter from the aponeurosis overlying it. The sac having been isolated and dealt with, the cord is held out of the way, and the first two of the sutures which are to approximate the conjoined tendon to Poupart's ligament are inserted, and their ends caught by pressure forceps. These sutures being held aside by an assistant, the pubic section of the filigree is placed upon the peritoneum, its narrow end being close to the pubic spine and its wide end at the inner margin of the internal ring. The conjoined tendon is then brought in close contact with Poupart's ligament over the filigree, by the two sutures already inserted, and as many more inserted as are deemed necessary, the bed in which the filigree lies being kept as dry as possible. In cases in which the muscular wall external to the internal ring is strong, the cord is placed in position and the iliac section of the filigree is taken from the sterilizer and is placed beneath the aponeurosis in such a way that its inner end lies over the internal abdominal ring and upon the cord for a space of three-fourths of an inch, the outer end being carried outward and laid upon the surface of the internal oblique muscle, one or two sutures holding it in place. If the above mentioned weakness is present, the muscular wall is divided from the ring outward toward the iliac spine for about an inch, and is separated from the peritoneum by the handle of a scalpel. Upon this peritoneum the outer end of the iliac section of the filigree is laid, being lightly sutured in place, and the muscles are brought together over it. The inner end lies as already described. Finally, the aponeurosis is sutured and then the skin wound. This method was employed with excellent results in 33 cases, in none of which was there a remote prospect of a cure by Bassini's operation.

THERAPEUTICS.

UNDER THE CHARGE OF

SAMUEL W. LAMBERT, M.D.,
PROFESSOR OF APPLIED THERAPEUTICS IN THE COLLEGE OF PHYSICIANS AND SURGEONS,
COLUMBIA UNIVERSITY, NEW YORK.

The Karell Milk Cure: Its Modifications and Indications.—ROEMHELD (*Monats. f. d. Phys.-diät. Heilkunde.*, 1909, i, 32) reviews the Karell milk cure and its various modifications. Karell, in 1865, published his results in over 200 cases treated by the use of skimmed milk. He gave about four to eight ounces of milk three or four times a day, and made an especial point that it should be taken very slowly Oertel thinks that the beneficial effects of such a cure are due simply to the restriction of fluids. He believes that such a starvation cure tends to a loss of good weight and consequent lowered vitality. Leyden agrees with this point of view, and adds that a weakened heart requires an especially nutritious diet. Hirschfeld has found this diet useful in the treatment of cardiac insufficiency, but thinks that an easily digestible mixed diet restricted in amount has equally good results. Lenhartz has made use of a modification of the original Karell cure in the treatment of chronic bronchitis, in the treatment of heart disease with passive congestion, and in order to hasten the loss in weight in obesity when the heart is insufficient. Lenhartz gives four doses of 200 c.c. of milk at four hour intervals. No other nourishment or fluids are allowed for a period of from five to seven days. In the succeeding two to six days other articles are gradually added to the diet, so that at the end of twelve days the patient is receiving a fairly liberal diet. Roemheld himself makes use of from 1000 to 1200 c.c. of milk on two days of each week. During the rest of the week a mixed diet containing two-fifths to three-fifths of the necessary amount of calories is ordered. He has found these milk days especially useful in the treatment of obesity associated with heart disease, nephritis, or gout. He uses them when the ordinary method of treatment fails or to maintain the loss of weight after the ordinary diet. Thus, a patient may control his weight for years by the interposition of two milk days a week with an ordinary restricted diet. Moritz uses large quantities of milk on a definite plan. He does not consider rest in bed essential, though the patient should be under observation for